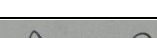
Patient Safety Incident Response Plan

April 2026 - March 2027

Version: Approved Draft

Reviewers:

Author	**Nina Winter**	**Risk, Quality and Patient Safety Lead**		**08/05/2026**
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Next Review Date: March 2027

Contents

Foreword

The NHS Patient Safety Strategy 2019 describes the Patient Safety Incident Response Framework (PSIRF) as “a foundation for change,” encouraging us to think and respond differently when a patient safety incident occurs.

The transition to PSIRF in 2023 marked a departure from how NUPAS traditionally approached patient safety, and it represented a significant cultural and system-wide shift in how we think about and respond to patient safety incidents and work each year to prevent their recurrence.

Our initial challenge was to move away from investigating incidents solely because they meet specific criteria within a framework and instead focus on the outcomes of the patient safety incident response that supports learning and improvement to prevent recurrence. We continue to focus and reflect on embedding the changes made in our previous plans and strengthen the quality principles we have established.

NUPAS will continue to involve our patients, their families and representatives through compassionate engagement to ensure that their voices are central to all our patient safety incident responses. PSIRF outlines best practices for this engagement, and our aim is to continue to ensure it is embedded at every stage of our incident response process. To support this NUPAS has undertaken a full review of its Duty of Candour process which was relaunched in 2025. A full review also of the Incident Reporting process has been completed with the policy ratified and launched in February 2026. These policies support our PSIRF policy and approach.

With the introduction of the Being Fair framework in May 2025, NUPAS will continue to support a fair, consistent and compassionate approach when a patient safety learning response raises concerns about an individual’s conduct or fitness to practice. The use of the Being Fair tool will enable NUPAS to:

- Support staff after patient safety incidents
- Avoid inappropriate individual blame when issues are systemic.
- Maintain an open and transparent learning culture where staff feel safe speaking up.
- Provide a structured, evidence-based process when concerns do relate to an individual.

As we continue to progress our PSIRP plan, we acknowledge that it will continue to be a live document and we will closely monitor its impact and effectiveness, responding and adapting our approach as needed.

We are supported in this by our commissioners, partner providers, and other stakeholders, enabling us to continue with this nationally driven change. We are grateful for the opportunity that PSIRF presents us to learn and improve, ensuring the safe, effective, and compassionate care of our patients, their families, and carers, while safeguarding the wellbeing of our staff.

Introduction

The Patient Safety Incident Response Framework (PSIRF) sets out NHS England's approach to establishing effective systems and processes for responding to patient safety incidents.

It should be viewed primarily as a learning and improvement framework, with a strong emphasis on creating a culture and system that supports ongoing improvement in patient safety through the way we respond to incidents.

A core principle of PSIRF is to undertake fewer investigations, but to conduct them more effectively.

PSIRF Strategic Aims
Compassionate engagement and involvement of those affected by patient safety incidents.
Application of a range of system-based approaches to learning from patient safety incidents.
Considered and proportionate responses to patient safety incidents.
Supportive oversight focused on strengthening systems and improvement.

This plan, along with the accompanying policy and guidelines, outlines how the framework is implemented in practice. The NHS Patient Safety Strategy encourages us to take a fresh approach to learning, redefining what it means for healthcare organisations, while PSIRF aims to promote proportionate and compassionate responses to patient safety incidents.

The plan is underpinned by our Incident Management (PSIRF) policy. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.
A glossary of terms used can be found at Appendix A

Scope

The purpose of the Patient Safety Incident Response Plan (PSIRP) is:

- To describe how we have developed our patient safety profile
- To describe how we will respond to patient safety incidents for the purpose of learning and improvement.

This plan sets out how NUPAS will respond to patient safety incidents between 1st April 2026 and 31st March 2027. This plan covers responses to patient safety incidents for the purpose of system learning and improvement.
This plan does not cover the responses needed for the following processes:

- Professional conduct/competence
- Litigation
- Coronial inquests
- Criminal investigations
- Complaints (unless the complaint also corresponds to a Patient Safety Incident in which case the two records will be linked on RADAR and the terms of reference for the combined investigation will be agreed).

This plan will be reviewed and updated on an annual basis. The annual review will incorporate any new learning, any changes to the organisational risk profile and include a review of linked improvement initiatives.

Our Services

NUPAS are an independent provider with 170 directly employed staff, who deliver both NHS and privately funded treatment. We provide NHS care across a national footprint in England with abortion care provision in local clinics in the following

regions.

- Staffordshire and Stoke
- Nottingham and Nottinghamshire
- West Yorkshire
- Buckinghamshire, Oxfordshire, Bedfordshire and Frimley
- Greater London
- Lancashire and South Cumbria
- Cheshire and Merseyside
- Greater Manchester
- Black Country

Our services offer safe, accessible abortion provision and sexual health signposting and contraception advice. All sites will continue to adhere to the principles set out in this plan and NUPAS PSIRF policy.

NUPAS has five core values aligning to our strategic objectives in order that we may provide a safe, effective, and person-centered service whilst treating everyone, both staff and patients with kindness, dignity, compassion, and respect. These compliment PSIRFs four strategic aims.

This plan covers all aspects of NUPAS patient safety incident reporting, analysis, and oversight.

Our Strategic Priorities

- To provide a safe, effective, and responsive service, specialising in termination of pregnancy and associated sexual health services.
- To treat people, including our clients and staff, with compassion, kindness, dignity and respect.
- To be a well-led organisation, with leadership and governance arrangements that support person-centered care, learning and innovation and promote an open and fair culture
- To be a Centre of Excellence in the delivery of sexual health services, specifically termination of pregnancy and contraception.
- To maintain financial stability to support current service and to invest in

new services as the opportunity arises.

Defining our Patient Safety Incident Profile

NUPAS remains committed to learning from patient safety incidents and has continued to build on the foundations established during years 1 and 2 of implementation, further strengthening our understanding and insights into patient safety. We hold bi-weekly Patient Safety Summits, overseen by the Risk, Quality and Patient Safety Lead, alongside a fortnightly 'Learning from Patient Safety Events' (LFPSE) review group that examines reported incidents. To provide a more robust forum for these discussions, each of these groups were extended to include both clinical and non-clinical representation.

The fortnightly LFPSE group oversees the outcomes of learning responses, critically reviews the quality of investigations, and ensures that systems learning has been considered. It also ensures that safety actions are consistently applied, using the HSSIB Learning Response Review and Improvement Tool (HSSIB, 2025).

The PSIRF framework does not impose fixed rules or thresholds for determining which types of patient safety incidents should generate learning for improvement, other than those specified as national requirements within this plan.

An essential element in developing the Patient Safety Incident Response Plan is understanding our patient safety profile and related activities. This enables us to plan effectively and ensure the necessary resources, systems, and processes are in place to deliver the plan.

To ensure the appropriateness of our PSIRP and to provide assurance on the efficacy of our PSIRF approach, NUPAS has undertaken a comprehensive review of all internal data sources that offer insights into patient safety. This has helped us to identify where the most meaningful learning for improvement can be achieved.

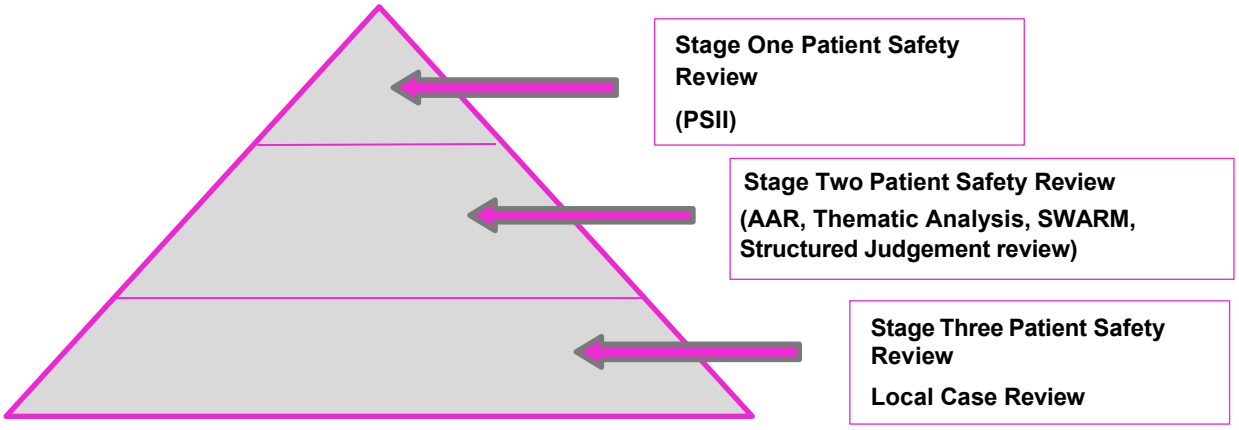
- **Understanding Patient Safety Incident Response Activity**

Since transitioning to the PSIRF framework in 2023, the nature and scope of patient safety response activity has changed. Figure 1 within the appendices gives an overview of the numbers of patient safety incidents received year on year and categorised by harm outcomes. Figures 2 to 5 shows the categorisation of those patient safety incidents received year on year. Figures 6 to 8 shows the categorisation of complaints received in 2024 and 2025.

In 2025 there were a total of 608 patient safety incidents recorded on RADAR. Of these, 262 were assigned a local learning response and investigated as a case review. Twelve patient safety incidents were escalated for a learning response within PSIRF, with 12 AARs undertaken and zero PSIIs

- **Three Tier Learning Response Model**

NUPAS will continue to use a three-tier model approach to respond to patient safety incidents. A systems-based methodology will be applied to individual incidents or clusters of events, particularly where contributory factors are unclear or where data analysis has identified a theme that warrants a specific method of review.



Since the introduction of PSIRF, NUPAS has determined that the PSIRF responses favoured within the business are the use of Case Reviews, AAR and PSII. Thematic Analysis will be decided based on the principles within the PSIRP.

As confidence in alternative learning reviews has grown, NUPAS has adopted systems-based approaches to incident response. This has enabled earlier identification of learning opportunities and contributed to the development of a stronger safety culture.

Local investigators within NUPAS are at liberty to determine the methodology most appropriate to their teams and service when undertaking an assigned learning response following a patient safety incident.

Patient Safety Oversight

Over several years, NUPAS has developed its governance processes to ensure effective oversight of patient safety information and to provide assurance that identified safety actions are triangulated and embedded within quality improvement

initiatives.

We remain committed to continually reviewing developments and incorporating guidance and feedback from national and regional NHS bodies, regulators, commissioners, partner providers, and other key stakeholders to identify and define areas requiring quality improvement. Moreover, we are keen to continually seek the patient perspective to understand how our services are received by them and through compassionate engagement uncover opportunities for continuous improvement.

The Corporate and Clinical Governance Committee (CCGC) is responsible for seeking assurance on the effectiveness of NUPAS quality and safety systems and processes, as well as the overall quality and safety of services delivered.

The Risk, Quality and Patient Safety Committee reports to the CCGC and provides updates on exceptions and actions. It is tasked with triangulating data and intelligence from multiple sources to confidently identify key risks to patient safety and service quality across the organisation. The Risk, Quality and Patient Safety Committee ensures that learning opportunities are appropriately identified, shared, and applied to mitigate both current issues and future risks.

- **Stakeholder Engagement**

To understand our patient safety concerns, a diverse range of stakeholders have been consulted:

- Chief Executive Officer
- Medical Director
- Clinical Director
- Patient Safety Specialist
- Risk, Quality and Patient Safety Lead
- Quality Assurance Lead
- Legal Affairs
- Freedom to Speak Up Guardian
- Patient Safety Partner
- Head of Operations
- Head of Human Resources
- Head of Nursing
- Clinical Staff

- Regional Managers
- Abortion providers collaborative network
- NUPAS patients, via incident / complaint investigation engagement

A comprehensive review of patient safety data from the previous year has been undertaken to identify persistent themes, evolving trends, and new areas requiring attention.

The generated profile has also been ‘sense checked’ to identify any areas which may not be reflective of current intelligence and insight. Data and information (both qualitative and quantitative) were received from the following sources and included in the analysis:

- Patient safety incidents
- Local learning reviews
- Safeguarding reviews
- Complaints
- Patients experience feedback
- Risk registers
- Regulatory Inspections
- Mortality reviews
- Inquest outcomes
- Staff survey results
- Legal claims
- Quality visits / Patient safety visits
- Freedom to Speak Up Outcomes
- Senior Leadership Team visits

- **Resource Planning**

The current structure, aligned with PSIRF standards, places significant reliance on quality and safety experts, nurses, and midwives employed by the organisation to carry out reviews. These are conducted within their allocated management time and alongside their routine Clinical Governance responsibilities.

Within Q3 2025/26 NUPAS reviewed how it assigned Learning Response Leads to patient safety incidents. As a result, case reviews are now managed by the operational

and / or clinical leadership within the region where the incident occurred. Where an AAR and PSII are determined to be required then these are assigned within the Risk, Quality and Patient Safety team who are appropriately trained and resourced to undertake these. Please refer to the Patient Safety Incident Response Management (PSIRF) Policy for guidance on who determines this and using what criteria.

To meet the ongoing requirements of the Patient Safety Incident Investigation Standards and PSIRF, continued investment in training for new starters and those staff identified as holding Learning Response responsibilities, or the review and sign off of, within the NUPAS leadership will be necessary.

- **Skills, Knowledge and Training**

NUPAS is committed to delivering formal and accredited training as laid out in the matrix below.

Training Type	Delivery Method	Duration	Who will complete the training
Essentials of patient safety for all employees Level 1	E Learning for Health	30 mins	All staff mandatory training
Essentials of patient safety – Access to practice Level 2	E Learning for Health	30 mins	Regional and Corporate Clinical Leadership Learning Response Leads Senior Leadership Team Quality Team
Essentials of patient safety for boards and senior leadership teams	E Learning for Health or via nationally approved PSS presentation.	45 mins	Senior Leadership Team
Level 2 Systems Approach to Patient Safety Incident Investigations	External PSIRF accredited trainer	12-hour program of study Or 1 day / 6-hour oversight training	Learning Response Leads LFPSE panel

In addition to the formal PSIRF training detailed above, NUPAS has created a suite of PSIRF related training presentations which are available to all colleagues through the RADAR documents module. These training presentations will form part of a 'self-service' library of supportive resources for the benefit of new starters to the business as well as those seeking to increase their confidence levels because of role change. The Risk, Quality and Patient Safety Team remain available to attend at regional base meetings to deliver sessions in person if preferred. We will continue to monitor

the training resources available to ensure that we build a comprehensive library that supports those colleagues working outside of core business hours.

Within 2025/26, NUPAS has identified an opportunity to restructure its Quality function because of staff turnover. An Interim arrangement enabled business continuity and gave insight into the scope for efficiency within the existing team structure. As a result, the vacant post was disbanded and replaced with a Risk, Quality and Patient Safety Lead which was recruited substantively in January 2026.

NUPAS does not currently have a Patient Safety Specialist within the business. Whilst colleagues are upskilled in this area, NUPAS is procuring external support from a Patient Safety Specialist on a consultancy basis. Training will commence for the Risk, Quality and Patient Safety Lead in the second quarter of 2026 with a view to bringing this function back in house within the financial year 2027/28. On successful qualification of the first NUPAS candidate, we will extend the training to a second member of the Risk, Quality and Patient Safety team to ensure contingency.

Our Patient Safety Incident Response Profile

As an organisation, we are strongly committed to service transformation and quality improvement initiatives that positively impact patient outcomes both nationally and locally, enhancing staff working practices, generating efficiency and both identifying and managing risk.

We have now completed the comprehensive quality improvement project focused on the entire patient pathway. This is now in evaluation to determine whether this localised improvement can be fully operationalised.

During the previous year's PSIRP, NUPAS declared its areas for local focus as the following themes, based on the data analysis undertaken at the time. Please see below for an update on progress and outcomes.

Patient safety incident type or issue	Planned response	Anticipated improvement route	Progress Update
Medication incidents (Administration, prescribing and issuing)	Quarterly Thematic Analysis with all cases receiving oversight from the Head of Nursing.	Feed actions into quality improvement plans agreed by LFPSE Group with oversight of progress through the Clinical & Medical Consultative Committee and the Corporate and Clinical Governance Committee	80 incidents in 2025/26, compared to 54 in 2024/25. This represents a small deterioration from 0.002% of total activity to 0.0026%. Within the subcategories associated with Medications Management incidents it is specifically 'Patient Compliance' and 'Storage' that warrant continued attention as these feature in our Top 10 of incident categories reported. Thematic analysis is completed quarterly with the head of nursing and quality assurance lead. Reviewed at CCC for learning and any actions required. Updated Abortion Booklet information on how to take medication. Implemented an EMA checklist to support the reduction of medication incidents. Prescriptions that have been sent to the

			chemist for Pills by post are now marked as 'sent to chemist' to negate the risk of the prescription being reused. We are also in the process of making system changes to hide prescriptions that have not been used within 3 months to negate the risk of them being used for a new episode of care.
Unexpected Surgical **Complication (intra operatively or post operatively)**	Structured Judgement Review	Feed actions into quality improvement plans agreed by LFPSE Group with oversight of progress through the Medical Consultative Committee and	Reviewed complications reporting and implemented reminder onto the form for staff to report complications resulting in moderate harm. Reviewed learning response hot debriefs and their facilitation immediately after the event. Hot Debrief training presentation has been created and shared. Teams now supplied with paper hot debrief forms to complete that can be uploaded to the incident reporting system to support timely management of discussions by staff. No theme of unexpected complication or location. Improved the process for reviewing reported complications to identify where these might also warrant an incident investigation. Implementation of the Surgical Group for collaborative learning. Piloting Surgical skills audit. Record Keeping audit has been implemented across the organization. Collaboration across clinical and non-clinical teams to identify process improvement and patient flow.

		Corporate and Clinical Governance Committee.	
Unexpected Surgical Complication resulting in severe physical and/or psychological outcome	Rapid Review and PSII	Feed actions into quality improvement plans agreed by LFPSE Group with oversight of progress through the Medical Consultative Committee and the Corporate and Clinical Governance Committee.	None at present- same principles as above.
Delayed Post Abortion Follow Up (appt not within 48 hours)	Local Case Review	Feed actions into quality improvement plans agreed by LFPSE Group with oversight of progress through Regional Leadership Team and the Corporate and Clinical Governance Committee.	27 incidents in 2025/26, compared to 30 in 2024/25. This represents a small improvement from 0.0010% of total activity to 0.0009%. The incident category continues to be one of our Top 10 categories recorded and warrants continued exploration for improvement. Clinical Support Team have now all completed training passports. Resource and capacity meetings weekly to monitor capacity for follow up appointments. Changes with the patient pathway in London have supported trialing new ways of providing appointments and opening up slots. More clinicians trained to do follow ups. CST policy under review and awaiting ratification to support improvements with aftercare and reducing the numbers of patients affected. Walk in clinics are now available within the London region which has improved the position. This has been well received and is

			now under trial in BOBs region. Change in process to seek out follow up slots directly with regional teams where Inform does not otherwise have capacity available. This has improved patient access and reduced the number of incidents reported.
Incidents regarding miscommunication or application of wrongly prescribed processes for patient care (correct processes not followed)	Quarterly Thematic Analysis, with all cases receiving oversight from Patient Safety Specialist	Feed actions into quality improvement plans agreed by LFPSE Group with oversight of progress through the Clinical Consultative Committee and the Corporate and Clinical Governance Committee.	24 incidents in 2025/26, compared to 95 in 2024/25. This represents an improvement from 0.0031% of total activity to 0.0008%. The incident category continues to be one of our Top 10 categories recorded and warrants continued exploration for improvement. Housekeeping applied to Radar incident categories to tighten up reporting themes where it was recognized that certain categories had become a 'catch all'. Localised feedback to staff members identified.
Missed Ectopic Pregnancy	Quarterly Thematic Analysis, with all cases receiving oversight from Clinical and/or Medical Director	Feed actions into quality improvement plans agreed by LFPSE Group with oversight of progress through the Medical Consultative Committee and the Corporate and Clinical Governance Committee.	4 incidents in 2025/26, compared to 1 in 2024/25. This represents a deterioration from 0.0000% of total activity to 0.0001%. Please note however, this figure is not matched against total number of ectopic pregnancies for the year so cannot be used as an accurate benchmark. Lead sonographer in post and performing audits/training passports/peer support through lunch and learn. Invested in better USS machines.

			CST team new policy update to support identification of ectopic pregnancy. CST team training passports. 78 correctly identified ectopic pregnancies detected within year as a result of improved awareness and referral pathways. Recording of this as a positive reporting category was introduced in November 2025. Lunch and learn sessions hosted by the Lead Sonographer for continued learning amongst scanning colleagues. Lead Sonographer reviewing pathways to consider risk appetite and exposure in line with staff and patient expectations. This is driven by the unavailability of surgical provision in London at present.
Clinical Record Keeping Omissions impacting on patient care	SWARM Huddle	Feed actions into quality improvement plans agreed by LFPSE Group with oversight of progress through the Clinical Consultative Committee and the Corporate and Clinical Governance Committee.	4 incidents in 2025/26, compared to 9 in 2024/25. This represents an improvement from 0.0003% of total activity to 0.0001%. Annual audit with head of nursing, QA Lead, risk quality and safety lead, and clinical lead. Monthly surgical audits. Professional development lead providing record keeping training. Discussed at supervision and via newsletters.
Hospital Transfer following surgical complication	AAR or Rapid Review according to presenting patient outcome	Feed actions into quality improvement plans agreed by LFPSE Group with oversight of progress through the Medical Consultative Committee	Hot debrief and review if further learning response is required. Skills drills completed at team meetings to ensure staff awareness of processes. Transfer letter updated to provide better quality handover. Surgical group now implemented to share

			learning and improvements across organisation. Surgical audits. Major hemorrhage policy updated with standardisation of grab boxes. Increased ILS training.

- **Patient Safety Incident Response Plan: National Requirements**

The table below categorises patient safety incident types that have a nationally mandated response, as set out in national guidance, regulations, or legislation.

Patient safety incident type	Required response	Anticipated Improvement Route
Incidents meeting the Never Events criteria	Locally Led PSII.	• Learning From Patient Safety Events Group • Medical Consultative Committee
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	Locally Led PSII.	• Learning From Patient Safety Events Group • Medical Consultative Committee
Deaths of patients detained under MHA or where MCA applies	Locally Led PSII.	• Safeguarding Strategy Group • Learning from Patient Safety Events Group
Mental Health related homicides	Referred to the NHS England. Regional Independent Investigation Team (RIIT) for consideration for an independent PSII. Locally led PSII may be required.	Respond to recommendations from external referred agency / organisation as required and feed actions into quality improvement plans with oversight of progress through the following: • Safeguarding Strategy group • Corporate and Clinical Governance Committee

Maternity / Neonate incidents meeting HSIB criteria	Refer to HSIB or SpHA for independent PSII.	Respond to recommendations from external referred agency / organisation as required and feed actions into quality improvement plans with oversight of progress through the following: • Risk, Quality and Patient Safety Committee • Corporate and Clinical Governance Committee
Child deaths	Refer for Child Death Overview Panel Review. Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel.	Respond to recommendations from external referred agency / organisation as required and feed actions into quality improvement plans with oversight of progress through the following: • Safeguarding Strategy Group • Corporate and Clinical Governance Committee
Death of a persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this.	Respond to recommendations from external referred agency / organisation as required and feed actions into quality improvement plans with oversight of progress through the following: • Safeguarding Strategy Group • Corporate and Clinical Governance Committee
Safeguarding incidents **i.e. babies, children, or young people are on a child protection plan; looked after plan or a victim of willful neglect or domestic abuse/violence** **Adults (over 18 years old) are in receipt of care and support needs from their local authority.** **Incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence**	Refer to local authority safeguarding lead. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.	Respond to recommendations from external referred agency / organisation as required and feed actions into quality improvement plans with oversight of progress through the following: • Safeguarding Strategy Group • Corporate and Clinical Governance Committee

Incidents in NHS screening programs	Refer to local screening quality assurance service for consideration of locally led learning responses.	Respond to recommendations from external referred agency / organisation as required and feed actions into quality improvement plans with oversight of progress through the following: • Risk, Quality and Patient Safety and Risk • Corporate and Clinical Governance Committee
Deaths in custody	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations Healthcare organisations must fully support these investigations where required to do so.	Respond to recommendations from external referred agency / organisation as required and feed actions into quality improvement plans with oversight of progress through the following: • Safeguarding Strategy group • Corporate and Clinical Governance Committee
Domestic Homicide	Identified by the police usually in partnership with the local Safeguarding Partnership (SP), with whom the overall responsibility lies for establishing review of the case. Where the SP considers that the criteria for a domestic homicide review (DHR) are met and establishment of a DHR panel, NUPAS will contribute as required by the DHR panel.	Respond to recommendations from external referred agency / organisation as required and feed actions into quality improvement plans with oversight of progress through the following: • Safeguarding Strategy group • Corporate and Clinical Governance Committee

See Figure 1b in the appendices for details regarding the occurrence of any of these Patient safety incident types within NUPAS since the inception of PSIRF.

- **Patient Safety Incident Response Plan: Local Focus**

PSIRF enables organisations to explore patient safety incidents in ways that are relevant to their specific context and the populations they serve. Following analysis of patient safety insights, drawn from a review of safety data, intelligence, and discussions held, we have identified the below patient safety priorities for local focus.

The outcomes of this analysis have shaped our patient safety profile for 2026/27, as detailed below.

Incident Category	Descriptor	Status	Planned Response	Anticipated Improvement Route
Medication	Relating to storage, prescription and issue of medication.	Continued from previous plan	Case Review Thematic analysis – 6 monthly Being Fair tool assessment	Videos to support patients taking medication. Improvements identified with INFORM.
Clinical policy and / or procedure not followed	Incidents regarding miscommunication or application of wrongly prescribed processes for patient care.	Continued from previous plan	Case Review	Continue with reflective practice for clinical colleagues. Organisational learning from outcomes of case reviews. Local feedback. Collaborate with relevant departmental leads to support targeted improvements and identify training needs.
Appointments, Treatment and follow up	Incidents regarding issues with movement of patients/ flow/ capacity, including patients requiring an unplanned post abortion follow up review.	Continued from previous plan	Case Review Thematic analysis – 3 monthly	Inform relevant departmental leaders of thematic analysis findings to support targeted improvements and identify training needs.
Documentation	Errors or omissions in record keeping.	Continued from previous plan	Case Review Clinical Record Keeping audits	Inform Clinical Trainer of audit findings to support targeted improvements and identify training needs.

Insufficient information provided to patient	Patient not appropriately informed regarding TOP / STOP options and / or procedures, or of the aftercare available.	New area of focus	Case Review	Report quarterly incident data to PIF for oversight
Medical Equipment	Any incident or complaint pertaining to the availability, appropriateness, servicing or maintenance of medical equipment within clinic.	New area of focus	Case review	ISO 13485 training for the Medical Device Lead. Better oversight of maintenance with new asset management system upon mobilization.
Missed Ectopic pregnancy	Cases where the opportunity to detect and diagnose an ectopic pregnancy has been missed leading to diagnosis outside of NUPAS.	New area of focus	Case review AAR as appropriate	Lead Sonographer review of identified incidents.

Local incident management reviews and specific patient safety reviews will contribute to the thematic analysis program where appropriate. All reviews will remain subject to existing NUPAS assurance processes, which may generate new improvement actions or support the enhancement of existing initiatives. NUPAS recognises that this initial local response plan will be subject to ongoing review and refinement. The findings from these investigations will be used to inform our wider patient safety improvement planning and initiatives.

- **Infection Prevention and Control Reviews**

In line with NHS England guidance NUPAS has aligned Infection Prevention and Control (IPC) Reviews with PSIRF. The Infection Prevention and Control Matrix is provided as an Appendix and details the types of learning responses that will be undertaken against specified infection prevention and control incidents.

Glossary of Terms

AAR – After action review. A structured facilitated method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful.

It aims to capture learning and identify the opportunities to improve and give individuals involved in the event an understanding of why the outcome differed from that expected or worked well. AAR generates insight from the various perspectives of the multidisciplinary team.

Case Review - A shortened investigative review of an incident or cluster of incidents to identify system issues and human factors affecting patient safety outcomes. A case review generates recommendations for actions to improve patient safety

Never Event - Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

PSII - Patient Safety Incident Investigation. PSIIs are conducted to identify underlying system factors that contribute to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type.

Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

PSIRF - Patient Safety Incident Response Framework. This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSIRP - Patient Safety Incident Response plan. Our local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed using a collaborative approach with the operational services, specialist risk and safety

leads and supported by analysis of local data.

SJR - Structured judgement review. Originally developed by the Royal College of Physicians. NUPAS follows the Royal College of Psychiatrists model for best practice in mortality review.

The SJR blends traditional, clinical judgement-based review methods with a standard format transferable to non-mortality cases. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.

This allows NUPAS to identify learning opportunities in the identified priority areas within the plan or deaths assessed as more likely than not due to problems in care. NUPAS is also then able to identify those patient safety incidents or deaths which may need to progress to PSII according to the given national priorities.

SWARM Huddle – A SWARM huddle is a debrief method used as soon as possible after an incident occurs at local level by a facilitator. Swarm-based huddles to identify learning from patient safety incidents.

Immediately after an incident, staff ‘swarm’ to the site to quickly analyse and debrief what happened and how it happened and decide what needs to be done to reduce risk. Swarms enable insights and reflections to be quickly sought and generate prompt learning.

MDT - The multidisciplinary team (MDT) review supports NUPAS teams to Identify learning from multiple patient safety incidents (including incidents where multiple patients were harmed or where there are similar types of incidents) and to explore a safety theme, pathway, or process whilst gaining insight into ‘work as done’ in a health and social care system. MDTs are facilitated by a Senior Leadership Team member.

Policy Detail

This Patient Safety Incident Response Plan should be read in conjunction with the following NUPAS policy documents:

- Patient Safety Incident Response Management (PSIRF) Policy
- Incident Reporting Policy
- Duty of Candour Policy

And the following National Guidance documents:

- NHS England Patient Safety Incident Response Framework
- NHS England NHS Patient Safety Strategy

References

Health Services Safety Investigations Body (2025) Learning Response Review and Improvement Tool. Resources

Patient Safety Incident Response Framework (2024). NHS England » Patient Safety Incident Response Framework

Patient Safety Incident Response Standards (2024) NHS England » Patient safety incident response standards

Appendices

Year	Near Miss	No Harm	Low Harm	Moderate Harm	Significant Harm	Death
2021	1	147	34	5	0	0
2022	10	253	74	20	4	0
2023	8	180	84	4	0	0
2024	37	616	47	19	5	2
2025	29	406	161	11	1	0

Figure 1a: Patient Safety Incident Data Analysis – Year on year

Response Type	Category	2024	2025
National priorities requiring patient safety incident investigation	Incidents meeting the Never Events criteria	0	0
	Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	2	0
	Deaths of patients detained under MHA or where MCA applies	0	0
	Mental Health related homicides	0	0
	Maternity/Neonate incidents meeting HSIB criteria	1	0
	Child deaths	0	0
	Death of a persons with learning disabilities	0	0
	Safeguarding incidents i.e., those on child protection plans, looked after plan or cases of willful neglect	16	19
	Domestic Homicide	0	0
Patient safety incident investigations conducted locally	Stage 1 Review (PSII)	13	2
	Stage 2 Review (AAR)	140	17
	Stage 3 Review (Case Review)	570	333

Figure 1b: Incidents reported within each of the categories listed since the inception of PSIRF into NUPAS.

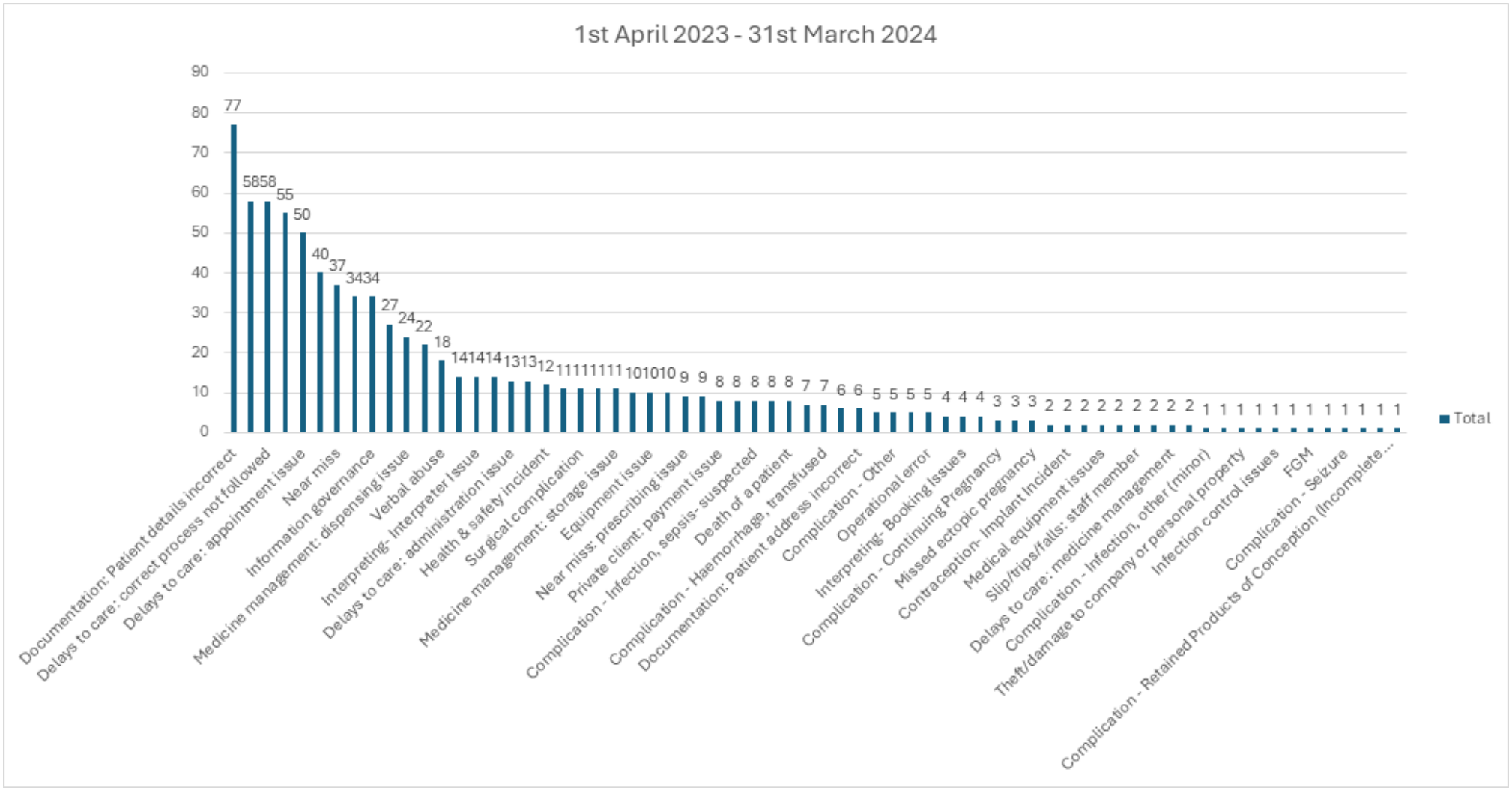


Figure 2: Patient Safety Incident reporting themes – 2023/24 (extracted from Vantage)

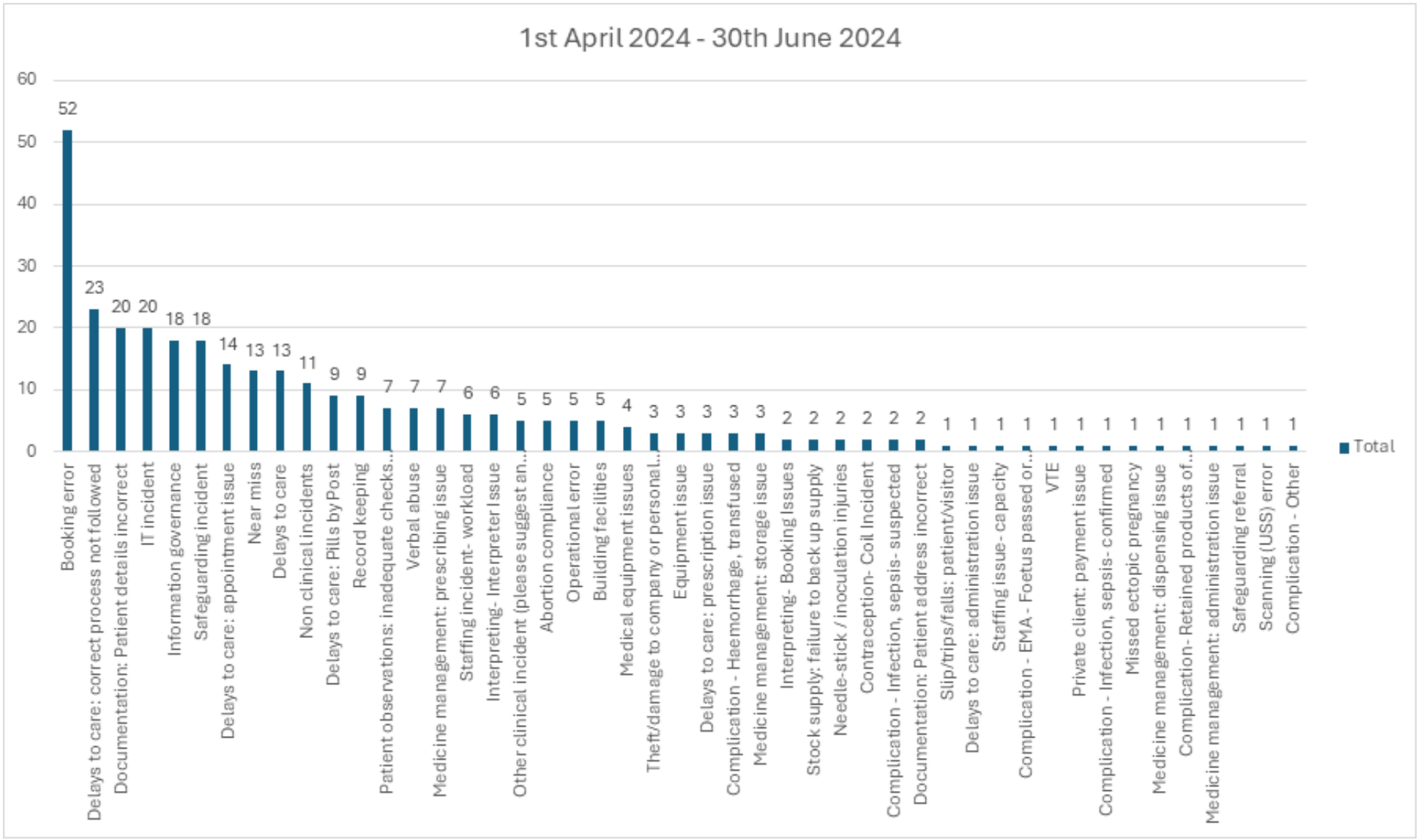


Figure 3: Patient Safety Incident reporting themes – 2024 (extracted from Vantage)

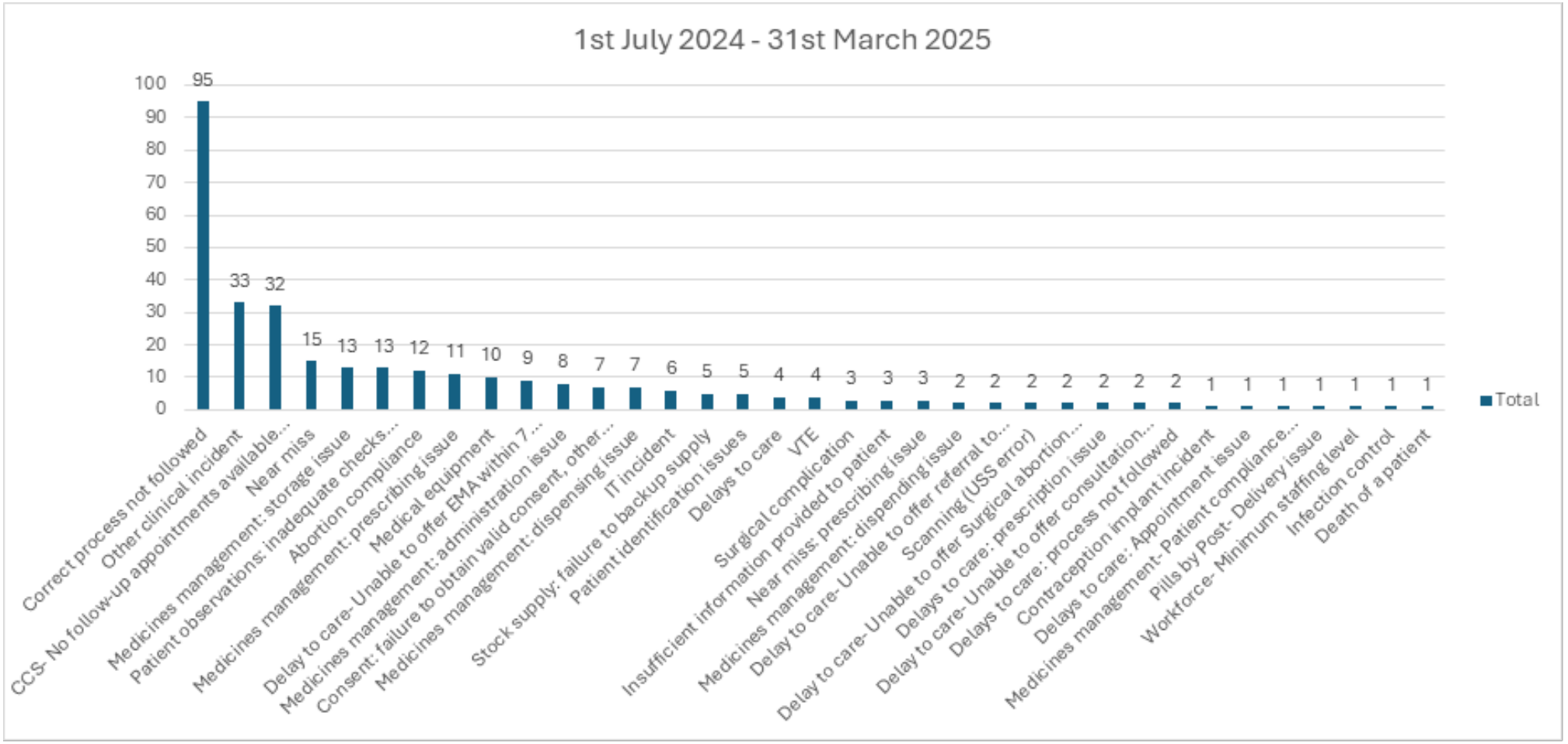


Figure 4: Patient Safety Incident reporting themes – 2024/25 (extracted from RADAR)

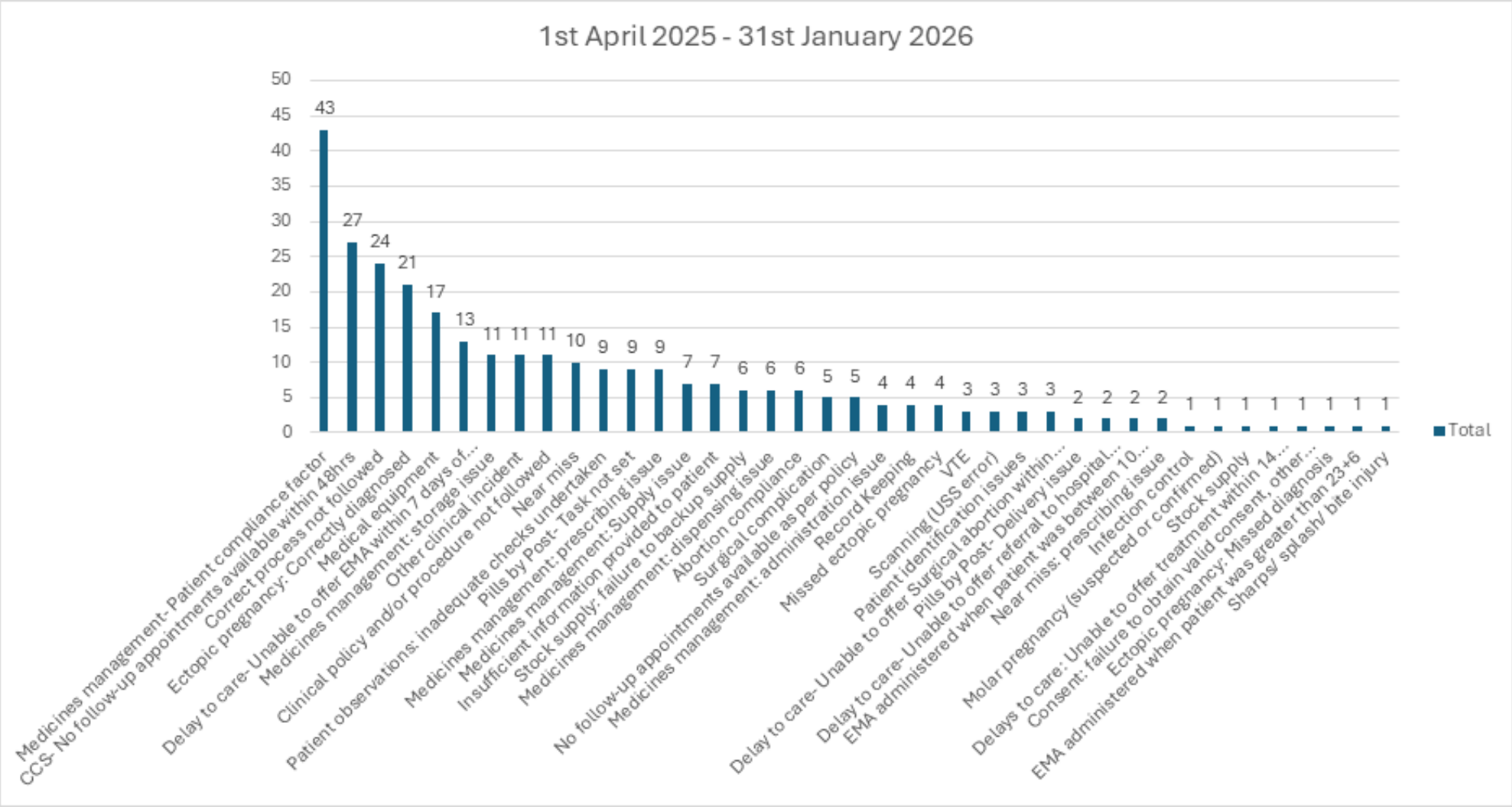


Figure 5: Patient Safety Incident reporting themes – 2025/26 YTD (extracted from RADAR)

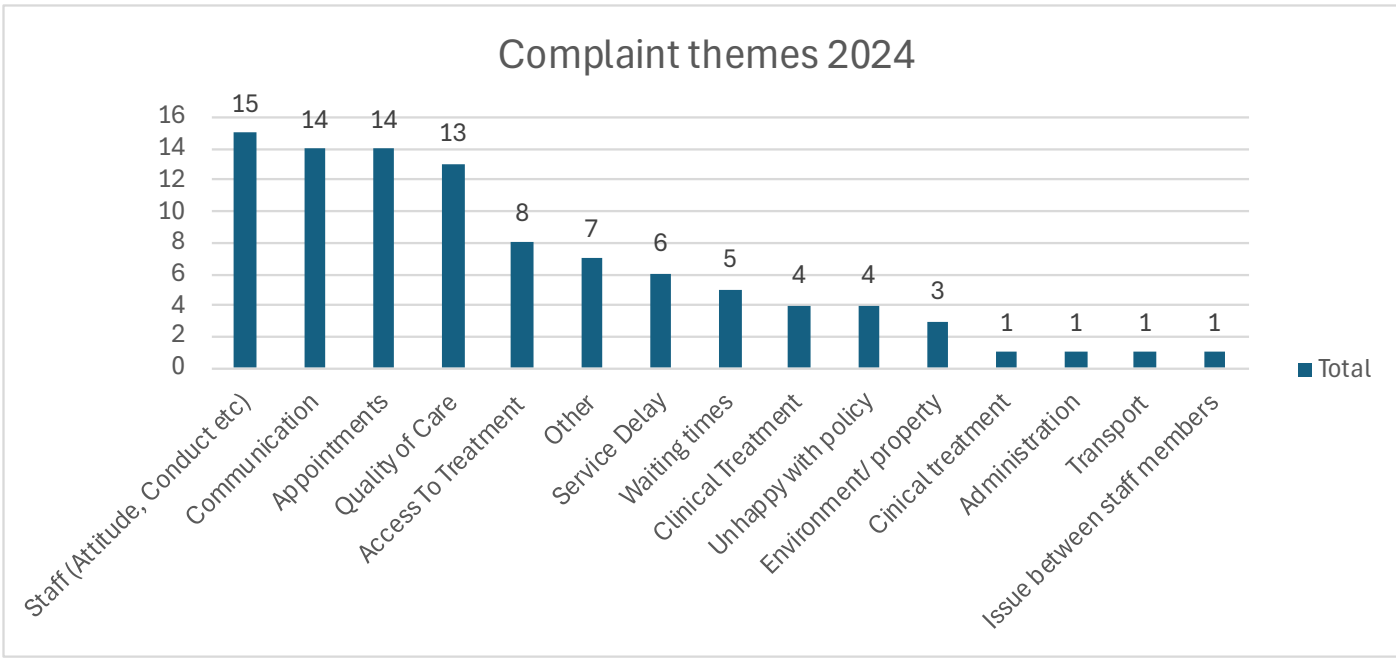


Figure 6: Complaint themes – 2024

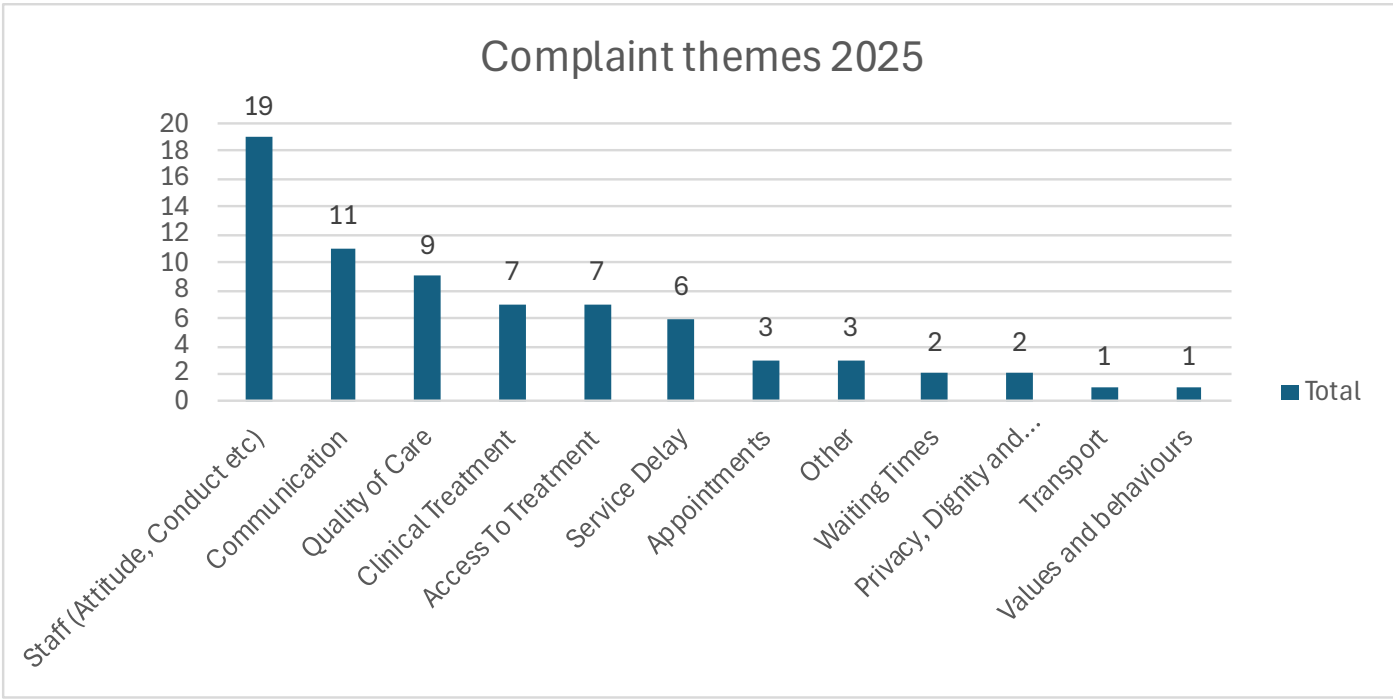


Figure 7: Complaint themes – 2025

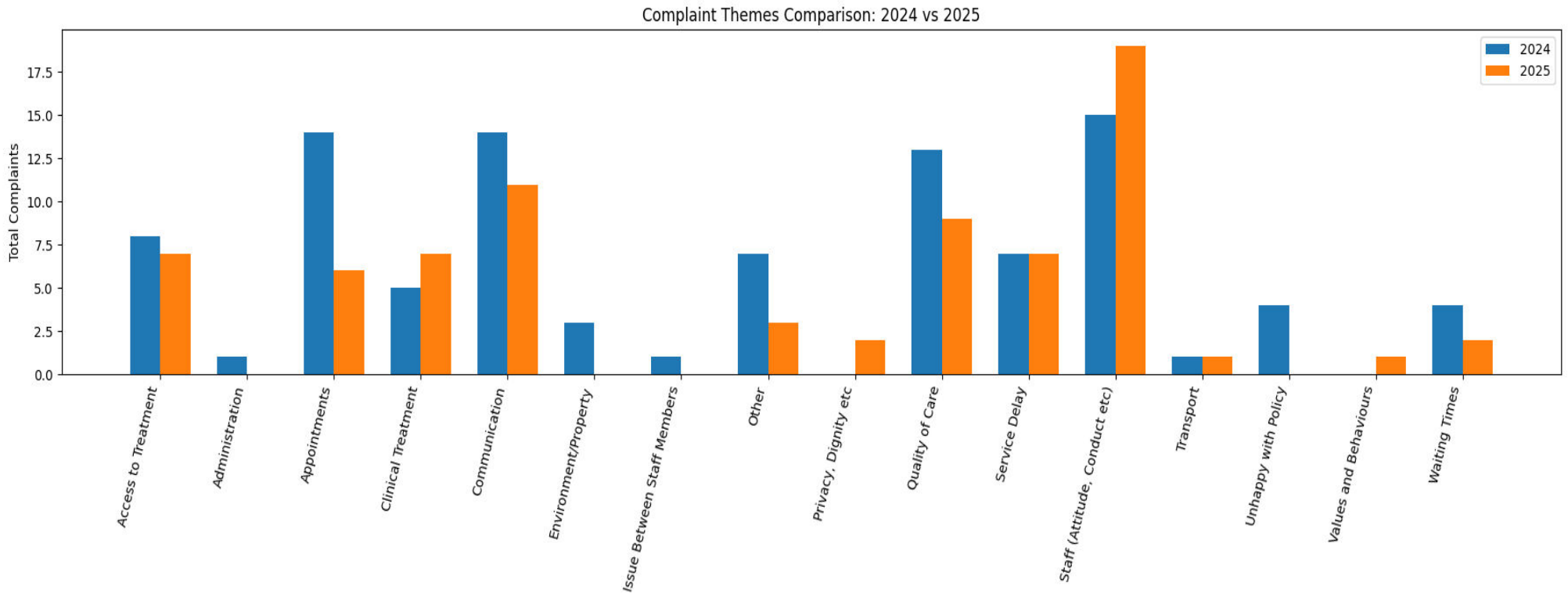


Figure 8: Complaint themes – Comparison 2024 vs 2025

IPC Incident	Mandatory Reporting	Radar Incident	PSII (Y/N)	IPC Response	Governance	Safety Actions/Improvement Plan
C.difficile Toxin	UKHSA HCAI DCS	Yes	No	Clinical Case Review AAR	IPC Committee	Radar Action Plan
MRSA BSI	UKHSA HCAI DCS	Yes	No	Clinical Case Review MDT Review	IPC Committee	Radar Action Plan
MSSA BSI	UKHSA HCAI DCS	Yes	No	Clinical Case Review MDT Review	IPC Committee	Radar Action Plan
GNBSI	UKHSA HCAI DCS	Yes	No	Clinical Case Review	IPC Committee	Radar Action Plan
HCAI incident or outbreak – death if part 1 or 2/severe harm	n/a	Yes	Assess if PSII.	Clinical Case Review Rapid review and agree investigation type	IPC Committee	Radar Action Plan
Pandemic Infection/Outbreak		Risk assess	Not routinely. Assess if an unexpected outcome	Clinical Case Review IPC meeting	IPC Committee	Radar Action Plan
IPC Policy breach	n/a	Yes	No	IPC review of Radar incident	IPC Committee	Radar Action Plan

Figure 9: Infection Prevention and Control Matrix (as per NHSE)